Michael L. Shelling, MD, LLC
Boynton Medical Arts Center
10075 S Jog Rd Suite #206 • Boynton Beach, FL 33437
Phone: (561)-737-1100 • Fax: (561)-731-4419

PATIENT INFORMATION:

Date: _____

Name _____ Social Security _____

Address_____

City, State, Zip_____Sex: M F

Phone _____ Date of Birth _____Age_____

Business Phone _____ Spouses Name_____

Occupation/Place of Employment_____

Emergency Contact Name and Number _____

Out of State Address _____

Out of State Telephone Number_____

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Who Referred You? _____ Office/Cell # _____

How Did You Hear About Our Office?_____

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List Allergies _____

List Medications You Are Taking_____

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INSURANCE: Please show your insurance cards to the receptionist after completing this form.

INSURANCE INFORMATION		
PRIMARY INSURANCE		SECONDARY INSURANCE

INS. CO. _____ INS. CO. _____

ADDRESS_____ ADDRESS_____

_____ PHONE _____ _____ PHONE _____

POLICY # _____ POLICY # _____

GROUP # _____ GROUP # _____

INSURED NAME _____DOB _____SEX: M F INSURED NAME _____DOB _____ SEX: M F

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AUTHORIZATION TO PAY / FOR MEDICARE, LIFETIME AUTHORIZATION

I authorize any holder of medial or information about me to release to my insurance company, and, for Medicare, Blue Cross/Blue Shield of Florida to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers or to the billing agent of BlueCross/Blue Shield of Florida, any information needed for this or a related insurance or claim. I permit a copy of this authorization to be used in place of the original. I further authorize payment of medical and/or surgical insurance benefit, otherwise payable to me, to the party who accepts assignment. I understand that I am financially responsible for those charges not paid by my insurance.

_____ _____

PATIENT SIGNATURE **DATE** **OTHER SIGNATURE/REASON IF PATIENT UNABLE TO SIGN** **DATE**